Screening, Brief Intervention, and Referral to Treatment

Marshall University SBIRT

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Stigma

- **Public-stigma**: Misperceptions, negative language, and negative beliefs about a certain group of the population
  - An imaginary stain we see on a person and those without the stain are superior
- **Self-stigma**: Internal beliefs about your "otherness" or inadequacy leading to isolation and lack of engagement in treatment
  - Pushes someone deeper into the addiction process
- Stigma towards addiction is one of the top barriers to accessing treatment
  - Hundreds-of-thousands of people who need help are not getting it, even though we have effective addiction interventions and treatment methods.

Vogel et al., 2006, 2007

Current Language	Suggested De-Stigmatizing Language	Reason
Addict, Junkie, Crack-head, User, Abuser, Alcoholic *please don't use "addict"	**Individual struggling with the disease of addiction. Individual not yet in recovery. A person with a substance use disorder.**	Person-centered language
Drug-addicted baby/ Drug-baby	**Infant who was neonatally exposed. Infant with pre-natal exposure. Infant experiencing withdrawals.**	Person-centered language & infants are not addicted
Non-compliant/ Resistant	**Struggling with Ambivalence. In the pre-contemplation stage. Choosing not to.**	Not-blaming; talking about the stages of change; offers change rather than label
Denial	**Ambivalent, Pre-contemplation stage**	Not-blaming; talking about the stages of change; offers change rather than label
Substance Abuse	**Substance Use Disorder**	Medical diagnosis
Drug of Choice	**Drug used/ Drug of Use/ Commonly Used Drug**	It's not a "choice"
Relapse prevention	**Recovery management, maintenance**	Positive, strength-based, stages of change
[AA/Faith-based/MAT/Abstinence] … is the only way	**Each individual takes a different path towards recovery or becoming drug free**	Offering opportunities and acknowledging the individual process
Drug overdose	**Drug poisoning**	Medicalize
Clean/Sober	**In recovery/ Drug free/ Free from illicit drugs or medication**	Stigma-free language not associating dirtiness with drug use
Chooses to use drugs	**Disease of addiction**	Medicalize the problem
Relapse	**Recurrence/ Return to Use**	The word relapse brings a lot of baggage
Abstinence	**Individual in recovery process**	Using abstinence language precludes those using medication assisted treatment
Replacement drugs	**Medication Assisted Treatment**	MAT may be part of the process for some

A Substance Use Disorder

…is a chronic relapsing brain disease

- craving for the object of addiction
- loss of control over its use
- continuing involvement with it despite adverse consequences

- Addiction is a description and not a formal diagnosis in the Diagnostic Statistical Manual of Mental Disorders (DSM-V).
  - Comes from the Latin term for "enslaved by" or "bound to"
  - The medical diagnosis and correct terminology is a Substance Use Disorder.

National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services. (2010*). Drugs, brains and behavior: The science of addiction.* Retrieved from http://www.drugabuse.gov/sites/default/files/sciofaddiction.pdf

What is SBIRT?

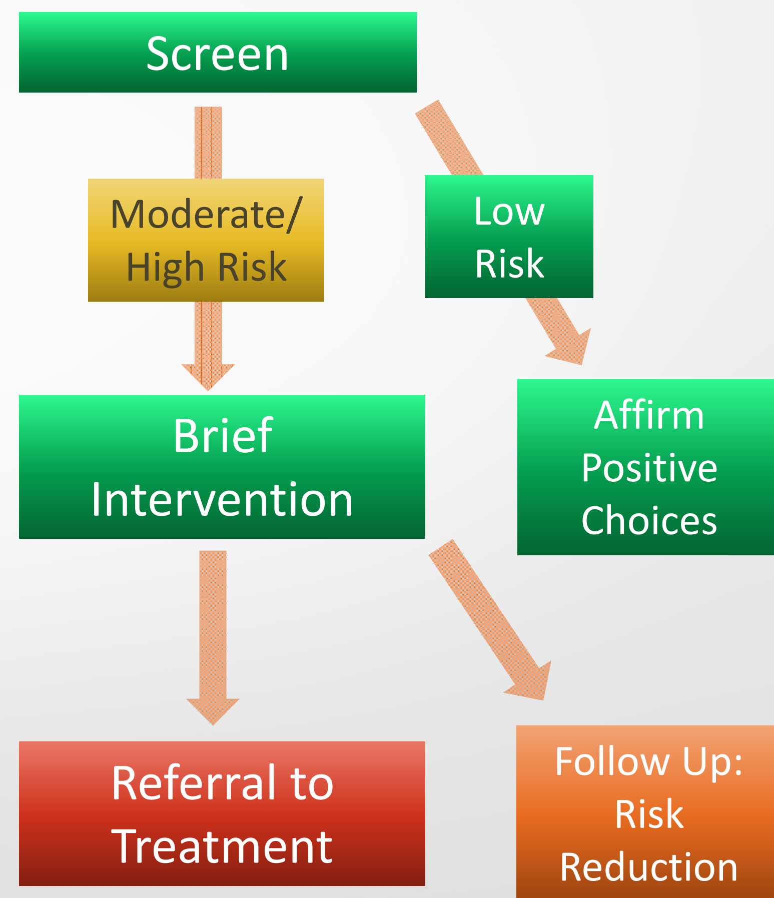
SBIRT Defined

Screening, brief intervention, and referral to treatment (SBIRT) is a comprehensive, integrated, public health approach, focused on the delivery of early intervention and treatment services.

An intervention based on "motivational interviewing" strategies

- **Screening:** Universal screening for quickly assessing use and severity of alcohol; illicit drugs; and prescription drug use, misuse, and abuse
- **Brief Intervention:** Brief motivational and awareness-raising intervention given to risky or problematic substance users
- **Referral to Treatment:** Referrals to specialty care for patients with substance use disorders

Treatment may consist of brief treatment or specialty AOD (alcohol and other drugs) treatment.



Source: Adapted from SBIRT Curriculum

SBIRT is used to screen EVERYONE* for:

- moderate to higher levels of risk of developing a substance use disorder.
- a substance use disorders (SUD).

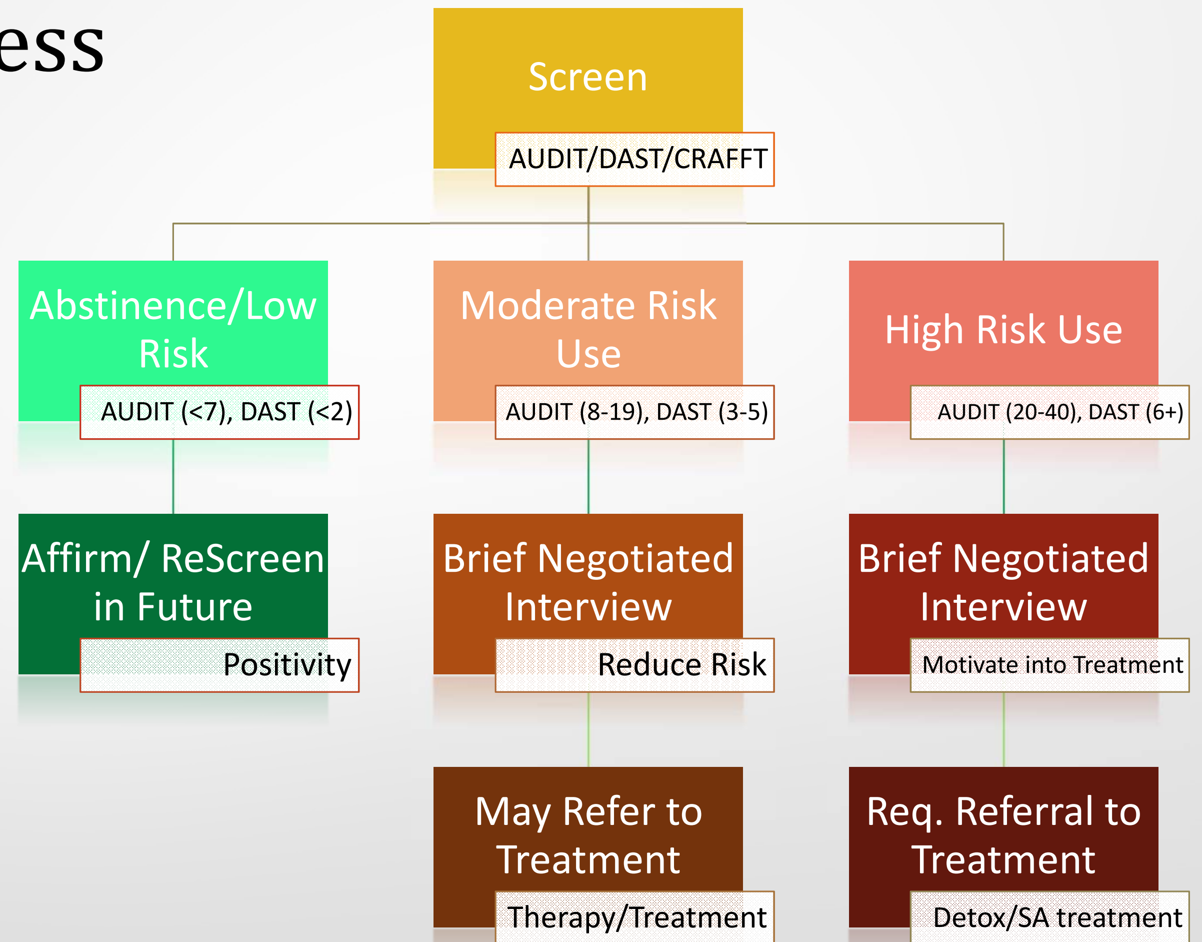
*SBIRT promotes Universal Screening!

The primary GOAL of SBIRT is to identify and effectively intervene with those who are at moderate or high risk for psychosocial or health care problems related to their substance use.

Source: Adapted from SBIRT Curriculum

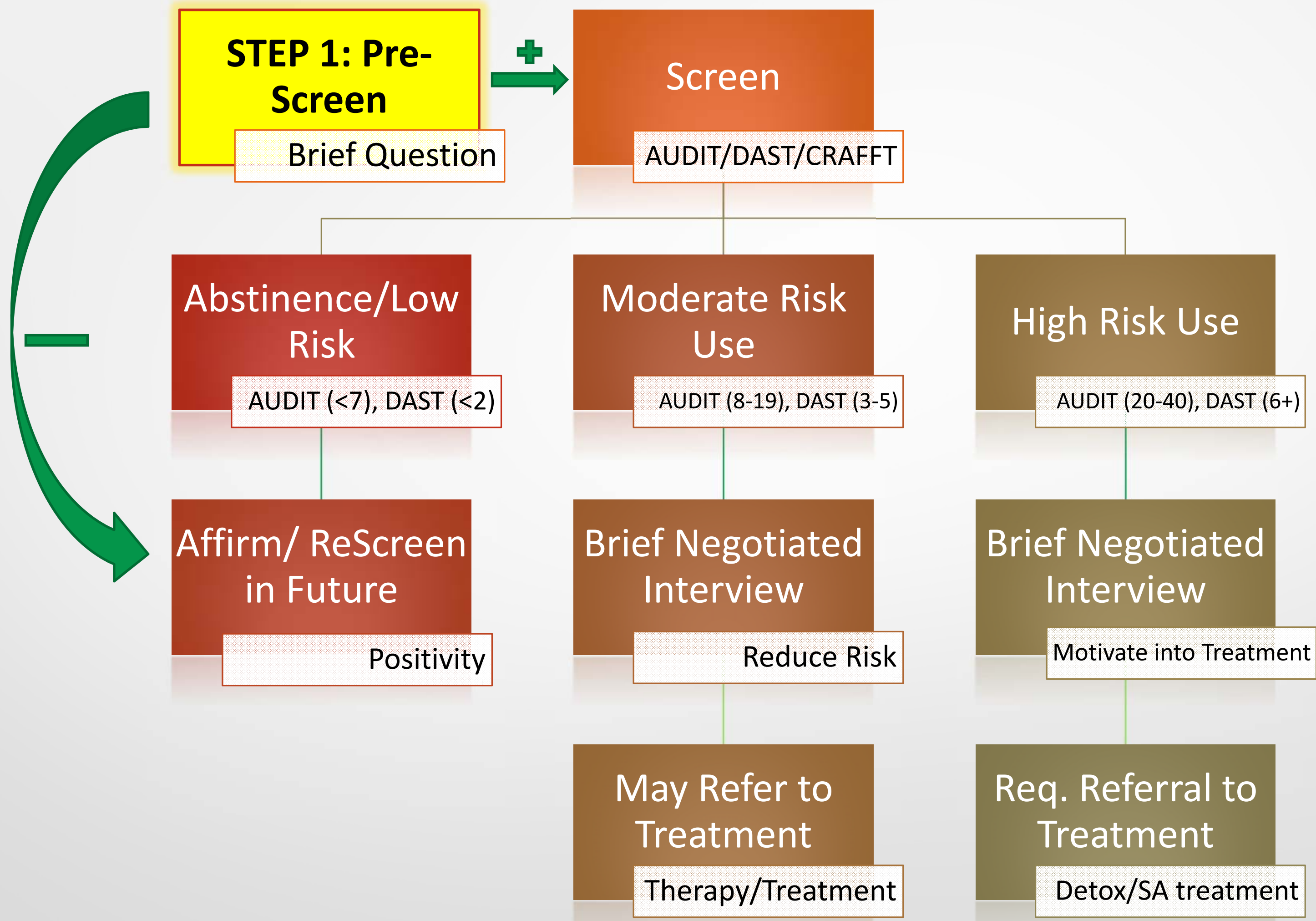
SBIRT Process

- 4-15 minute brief intervention
- Utilized WHO validated screening tools
- 20% change in behavior from brief interaction



Source: Adapted from SBIRT Curriculum

The “S” in SBIRT: Screening



Source: Adapted from SBIRT Curriculum

Step 1

1. Pre-Screen

- In the past year, have you had 3 or more drinks containing **alcohol** on any one day?
- In the past year, have you used **prescription medication** more than prescribed or that was not prescribed to you?
  - More comprehensive: Are you currently using prescription medication and if so, what & for how long?
- In the past year, have you used **drugs** other than those required for medical reasons?
- In the past year, have you used **tobacco** (cigarettes or any tobacco use)?

Mental Health:

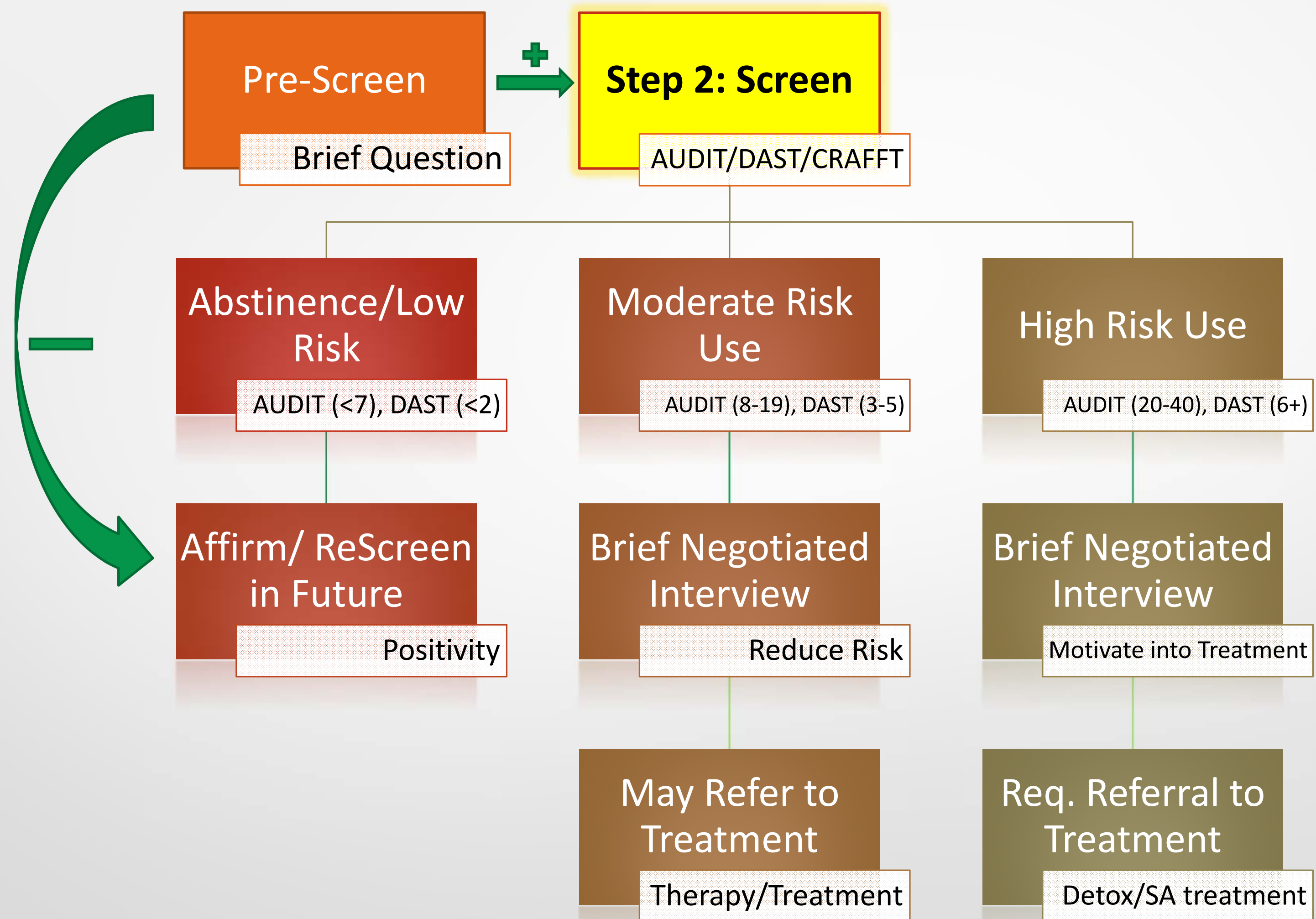
- In the past year, have you felt down or **depressed**?
- In the past year, have you felt **anxious** or helpless?

Suicide:

- Have you ever had thoughts about harming yourself?

If yes to any, complete Step 2: Brief-Screen. If no, at this time, nothing further is necessary but affirm the client's positive health decisions!

Adapted from SBIRT Curriculum



Pre-Screen
Brief Question
+
Step 2: Screen
AUDIT/DAST/CRAFFT
–
Abstinence/Low Risk
AUDIT (<7), DAST (<2)
Moderate Risk Use
AUDIT (8-19), DAST (3-5)
High Risk Use
AUDIT (20-40), DAST (6+)
Affirm/ ReScreen in Future
Positivity
Brief Negotiated Interview
Reduce Risk
Brief Negotiated Interview
Motivate into Treatment
May Refer to Treatment
Therapy/Treatment
Req. Referral to Treatment
Detox/SA treatment

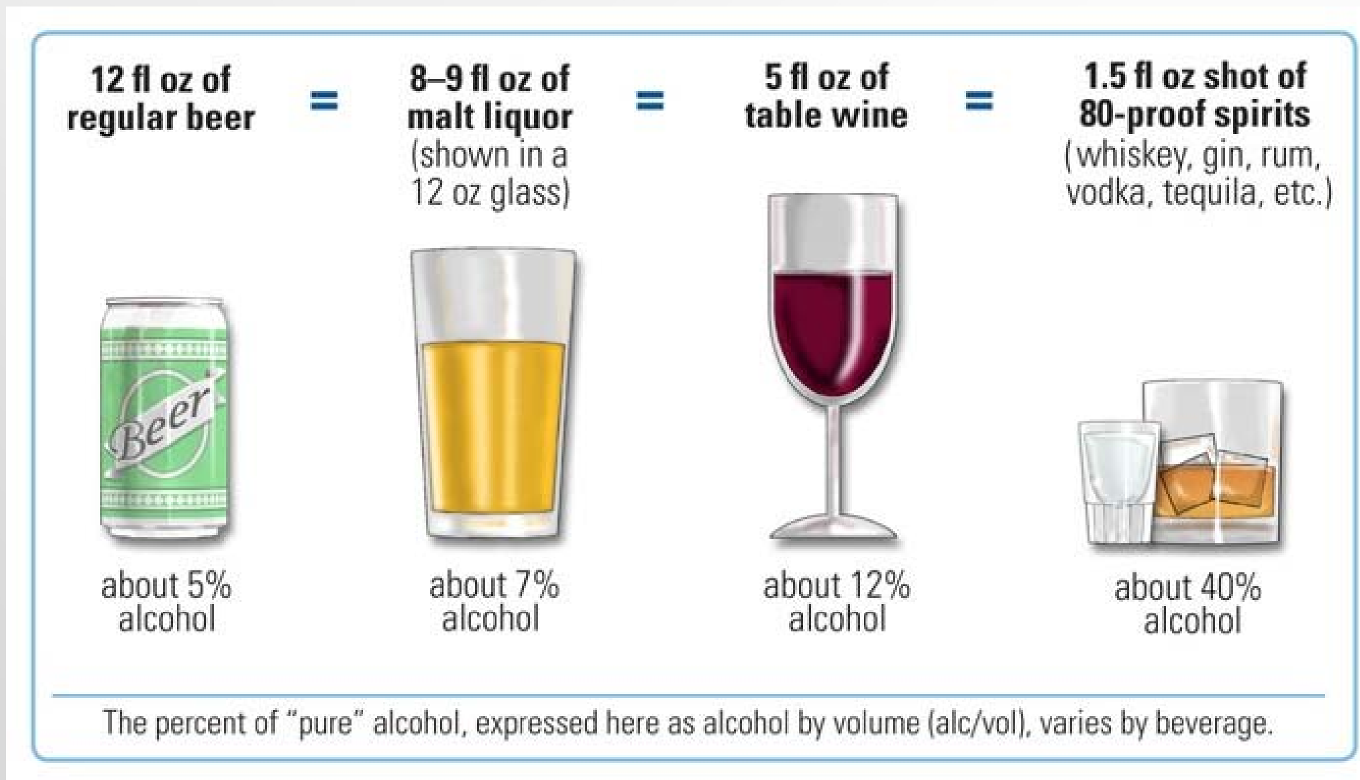
Step 2

Concern	Brief-Screen
Alcohol (18+)	US Alcohol Use Disorder Identification Test (USAUDIT)
Prescriptions/Drugs (18+)	Drug Abuse Screening Test (DAST)
Alcohol or Drug Use (Under 18)	CRAFFT
Tobacco	No Brief Screen - Provide quit line information: 1-800-QUIT-NOW (800-784-8669) or 1-877-966-8784
Depression	Patient Health Questionnaire 9-item (PHQ-9)
Anxiety	Generalized Anxiety Disorder 7-item (GAD-7)
Suicide	Columbia-Suicide Severity Rating Scale (C-SSRS)

Score based on scale instructions & provide brief intervention or refer to necessary services

Adapted from SBIRT Curriculum

When Screening, It's Useful To Clarify What One Drink Is!



Recommended Limits

- Men = 2 drinks per day/14 per week
- Women/anyone 65+ = 1 drink per day or 7 drinks per week

Binge drinking

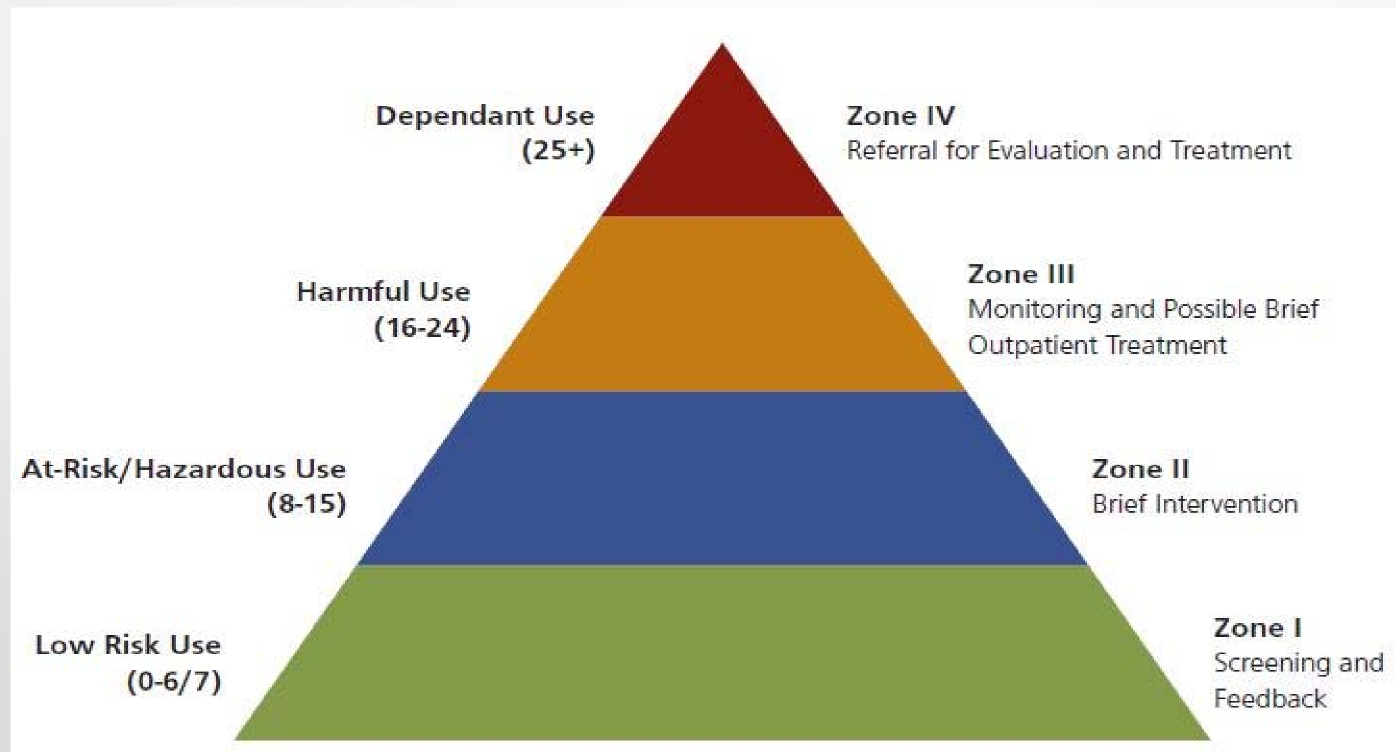
≥5 for men or ≥4 for women/anyone 65+

USAUDIT Questions	0	1	2	3	4	5	6	Score
1. How often do you have a drink containing alcohol?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 drink	2 drinks	3 drinks	4 drinks	5-6 drinks	7-9 drinks	10 or more drinks	
3. How often do you have X (5 for men; 4 for women & men over the age of 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily	
4. How often during the past year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
5. How often during the past year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
How often during the past year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
How often during the past year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
Have you or someone else been injured because of your drinking?	No		Yes, but not in the past year		Yes, during the past year			
Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the past year		Yes, during the past year			
Total In Each Column:								
							Total Score:	

AUDIT Scoring

Scoring the AUDIT: Use the number at the top of the column (0-6) to total the individual's score. For each item selected assign it the necessary points (from the top column) and total those for the final score.

Column 1 responses = 0 points each, column 2 responses = 1 point each, column 3 = 2 points, column 4 = 3 points, column 5 = 4 points, column 6 = 5 points



Common Prescription Drug Misused

- Opioids: Substance that act on the nervous system. (Ex. morphine, tramadol, oxycodone, hydrocodone, methadone, fentanyl)
- Benzodiazepines: Sedative, anxiolytic, or anticonvulsant medications. (Ex. Valium, Xanax, Klonopin)
- Stimulants: Psychoactive drugs to improve mental or physical functions (Ex. Ritalin, Concerta, amphetamine, dextroamphetamine, methylphenidate
- Sleep aids (zolpidem, zaleplon, eszopicione)
- Other assorted including clonidine (sedative), carisoprodol (muscle relaxant), & Neurontin (gabapentin).

CDC 2015

DAST(10) Questionnaire

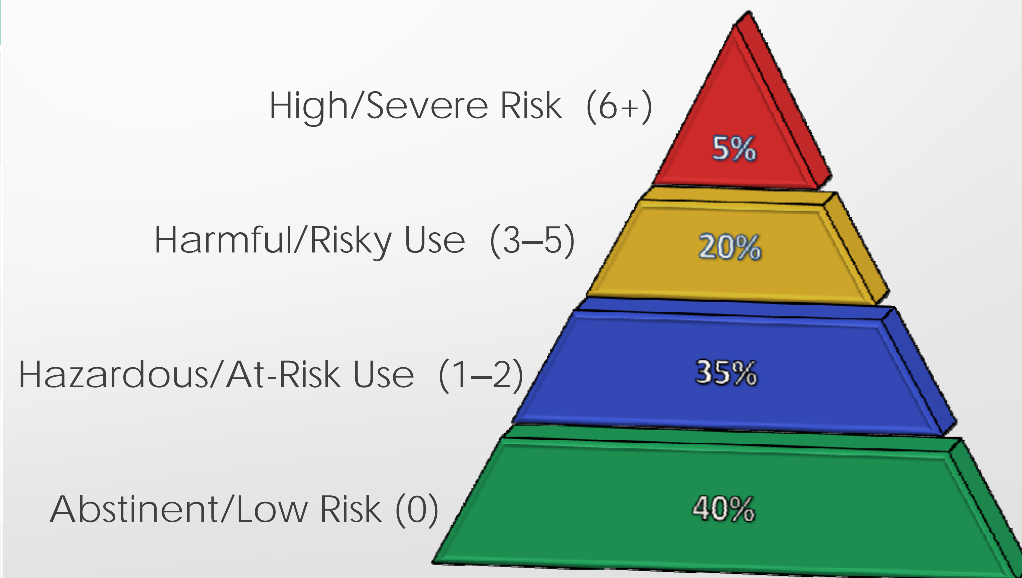
In the past 12 months:	Circle Response	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you abuse more than one drug at a time?	Yes	No
3. Are you always able to stop using drugs when you want to?	Yes	No
4. Have you had "blackouts" or "flashbacks" as a result of your drug use?	Yes	No
5. Do you ever feel bad or guilty about your drug use?	Yes	No
6. Does your spouse/partner/parents/ friends ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, infection, etc.)?	Yes	No

- Shortened version of DAST 28, containing 10 items, completed as self-report or via interview.
- Screening questions for at-risk drug use
- Developed by Addiction Research Foundation, now the Center for Addiction and Mental Health
- Yields a quantitative index of problems related to drug misuse
- Strength: Sensitive screening tool for at-risk drug use
- Weakness: Does not include alcohol use
- Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement.

DAST(10) Scoring

Score 1 point for each questions answered “yes,” except for question 3, for which “no” receives 1 point.

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation - referral
6-8	Substantial level	Intensive assessment -referral
9-10	Severe level	Intensive assessment - referral



Yudko et al., 2007

CRAFFT (<21 Alcohol & Drug Screen)

CRAFFT is a mnemonic acronym of first letters of key words in the six screening questions. The questions should be asked exactly as written. The first 3 questions are considered the pre-screen.

Questions	Circle Below	
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.	Yes	No
2. Smoke any marijuana or hashish?	Yes	No
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	Yes	No
If yes, to any above continue below. If no, only ask number 4.		
4. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	Yes	No
5. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	Yes	No
6. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	Yes	No
7. Do you ever FORGET things you did while using alcohol or drugs?	Yes	No
8. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	Yes	No
9. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	Yes	No

SCORING INSTRUCTIONS:

- Each "yes" response in Part B scores 1 point.
- **A total score of 2 or higher is a positive screen, indicating a need for additional assessment.**

Key Points for Screening

- Screen **everyone**.
  - Don’t pre-screen if you are seeing someone who you know is in active addiction. Rather assess for overall use to make referral source or intervention decisions (depending on profession).
- Prescreening can be included in another health and wellness survey.
  - Could be built into Home Care screening procedures or outpatient intake screens
- Screen for **both** alcohol and drug use including prescription drug abuse and tobacco.
  - *Remember: People may not thinking they are taking prescriptions drugs incorrectly (too many or crushing).*
  - Sharing is common in this community and in Appalachian culture (they mean well).
- Explore **each** substance; many patients use more than one.
- Use a validated tool (AUDIT, DAST, CRAFFT)
- **Follow up** positives or "red flags" by assessing details and consequences of use.
- Use your MI skills and show **nonjudgmental**, **empathic** verbal and nonverbal behaviors during screening.

Adapted from SBIRT Curriculum

Where Do We Go From Here?

Pre-Screen
Brief Question

+

Screen
AUDIT/DAST/CRAFFT

Abstinence/Low Risk
AUDIT (<7), DAST (<2)

Moderate Risk Use
AUDIT (8-19), DAST (3-5)

High Risk Use
AUDIT (20-40), DAST (6+)

–

Affirm/ ReScreen in Future
Positivity

Brief Negotiated Interview
Reduce Risk

Brief Negotiated Interview
Motivate into Treatment

May Refer to Treatment
Therapy/Treatment

Req. Referral to Treatment
Detox/SA treatment

Next training is on the Motivational Interviewing skills necessary to conduct a Brief Negotiated Interview (BNI)

Adapted from SBIRT Curriculum

Motivational Interviewing Skills

Learning the necessary **basic** skills and techniques from the evidence-based practice of Motivational Interviewing in order to apply them to clients/patients in the next step of SBIRT (Brief Intervention).

Why Should We Be Interested in a Client's Motivation for Behavior Change?

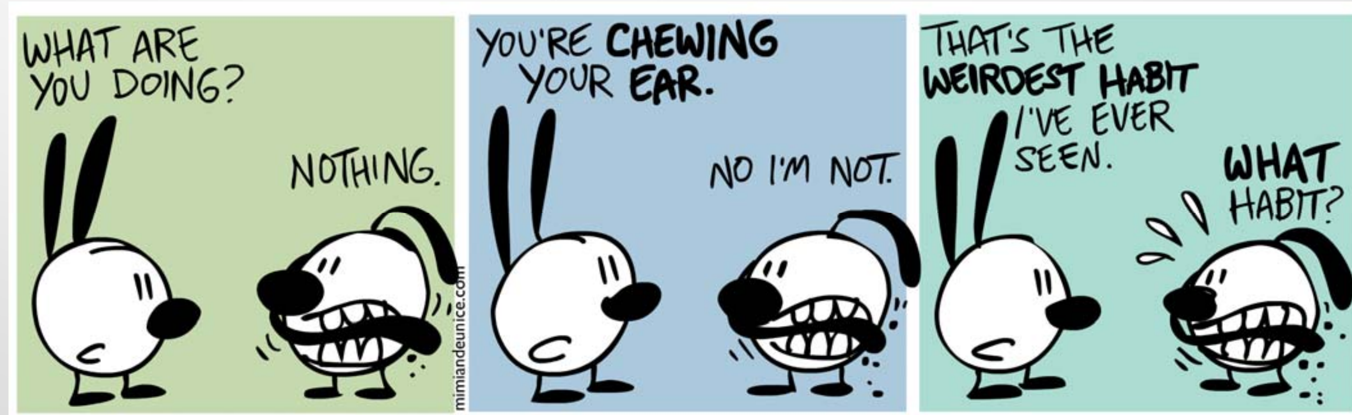
Adapted from SBIRT Curriculum

Where Do You Meet Someone?

Stages of Change

1. Precontemplation

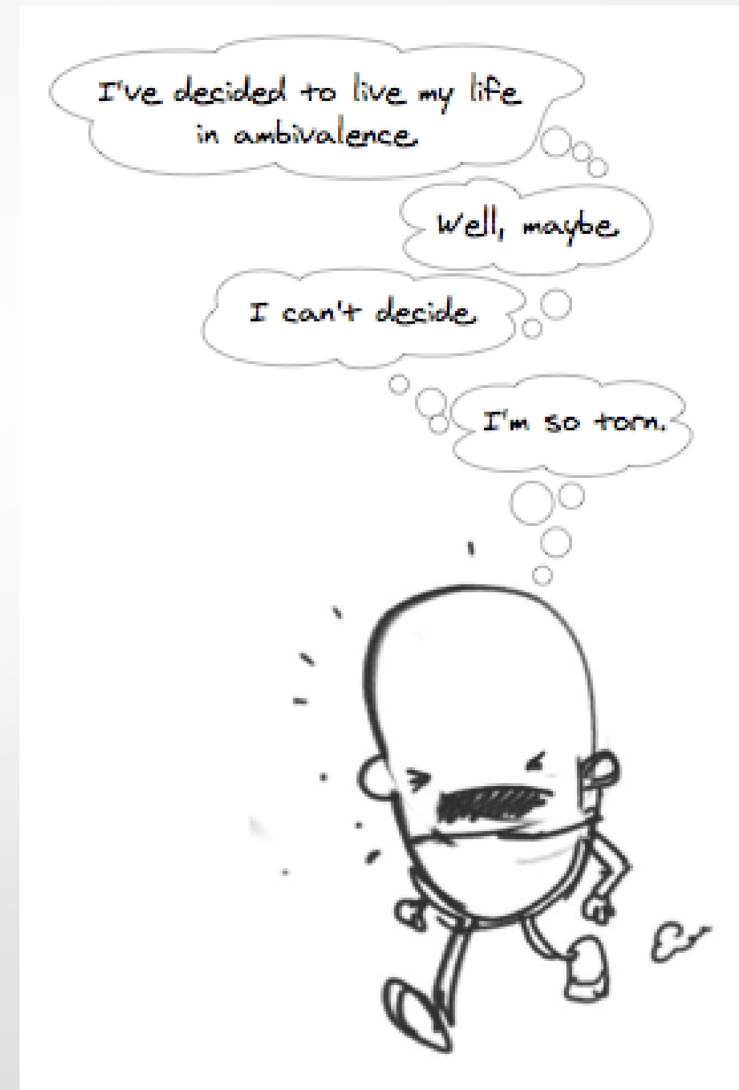
- Unaware that their behavior is problematic
- Not planning on making a change in the foreseeable future (next 6 months)
- *Interventions*
  - Education, pros-cons of change
    - Normally they underestimate the pros and overestimate the cons
  - Encourage intentionality and mindful decision making
  - Highlight "stuckness," negative emotions, and benefits of change



(Prochaska & DiClemente, 1984; Prochaska & Velicer, 1997)

2. Contemplation

- Starting to consider making a change in the next 6 months
- Greater awareness about the pros and cons of change
  - However, the pros and cons appear about equal to them
  - This is defined as ambivalence (“yes but…”)
- *Interventions*:
  - Reduce the cons of changing behavior
  - Highlight the positives of change – long term
  - Watch for “stuckness”
  - Focus on “tipping the scales”
- This stage is a perfect intervention stage



(Prochaska & DiClemente, 1984)

3. Preparation

- Pre-action stage (ie. getting ready to change)
- Many people rush through this stage or minimize it
- Preparation is key because people need to imagine what change looks like and how his/her life will be impacted.
  - "What do you need?"
  - "How will you do it?'
  - "What else should be considered?"
  - "What is it going to look like?"

- *Interventions*:
  - focus on gathering information
  - developing strategies & plans for change
  - discussing the impact of the change, setting a date, informing others, behavior-contracting
  - building on self-efficacy
- Number 1 concern: "What happens if I fail?"

(Prochaska & DiClemente, 1984; Prochaska & Velicer, 1997)

4. Action

- People are “in action”- Change is being made and has been made within the past 6 months.
- Focus on strengthening the individual's commitment to change and reinforce the positive changes.
- *Interventions*:
  - Provide support
  - Teaching techniques for maintaining change
  - Sticking with something even when it’s hard
  - Normalizing difficulty with change or feeling uncomfortable with change
  - Supplementing other activities
  - Self-rewarding activities as changes are made and maintained
  - Avoiding negative people, places, and things
  - Re-negotiate areas when the individual is continuing to struggle

(Prochaska & DiClemente, 1984; Prochaska & Velicer, 1997)

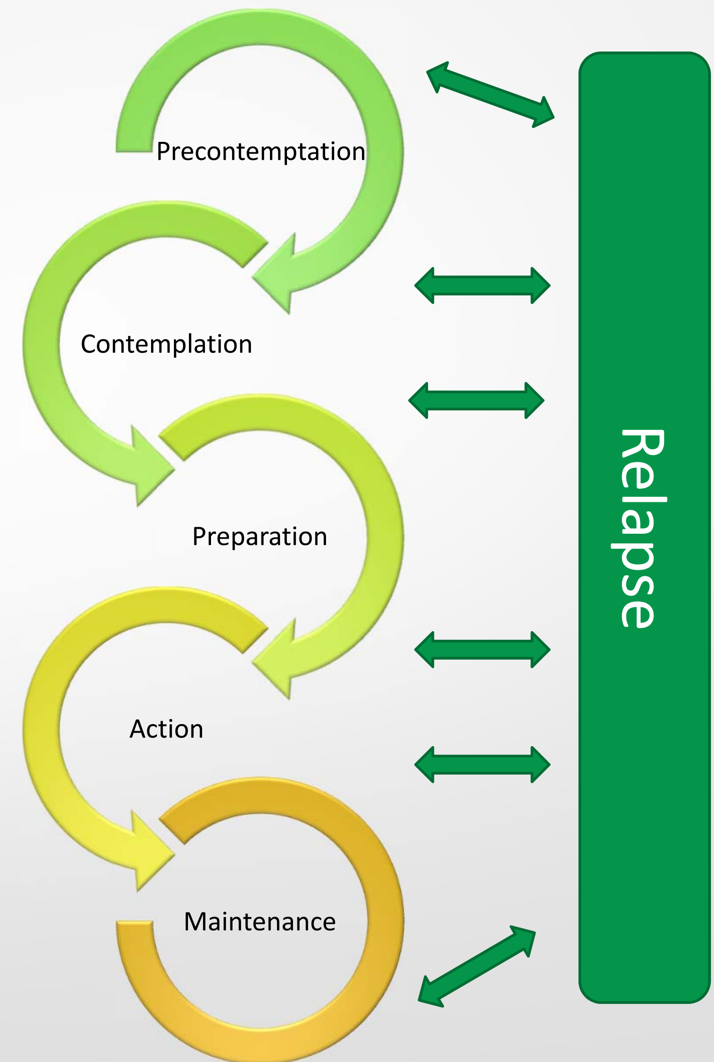
5. Maintenance

- People have made a change more than 6 months ago
- Promote awareness about potentially tempting situation – stress, anniversaries
- *<u>Interventions</u>*:
  - Help someone identify who can support them and who will continue to provide support and trust
  - Engage in healthy behaviors and continue to grow habit/hobby/skill list
  - Avoid temptation
  - Consistently review progress
  - Anticipate relapse

(Prochaska & DiClemente, 1984; Prochaska & Velicer, 1997)

Relapse

- Relapse is not inevitable however it may be an important step or process for someone to learn from and grow from.
  - We wear a seatbelt not because we expect to crash but we should be prepared if it were to happen.
- Not all relapses are treated equal.
  - Lapse vs. Relapse
- They should be planned for but not expected or required.
- Relapse can happen at or during any stage.
- It is not a stage of change.



(Prochaska & DiClemente, 1984; Prochaska & Velicer, 1997)

What are Some Reasons People Change?

1. ?
2. ?
3. ?
4. ?
5. ?

Adapted from SBIRT Curriculum

What are Some Reasons People Don't Change?

1. ?
2. ?
3. ?
4. ?
5. ?

Adapted from SBIRT Curriculum

Change

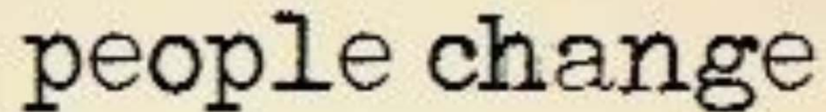
What are Some Reasons People Cite for Changing?

1. **Sick and tired of being sick and tired**
2. **For their family, kids, partner**
3. **Want a new future**
4. **Medical or health reasons**
5. **Improved life conditions**

What are Some Reasons People Cite for NOT Changing?

1. **Don't know how**
2. **Don't have the resources**
3. **Don't know who to ask**
4. **Scared**
5. **Fear of failure**

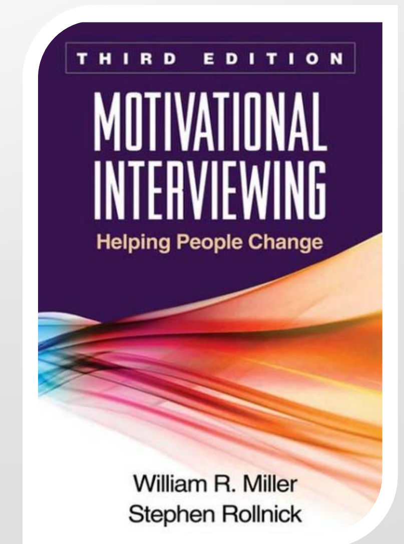
Adapted from SBIRT Curriculum



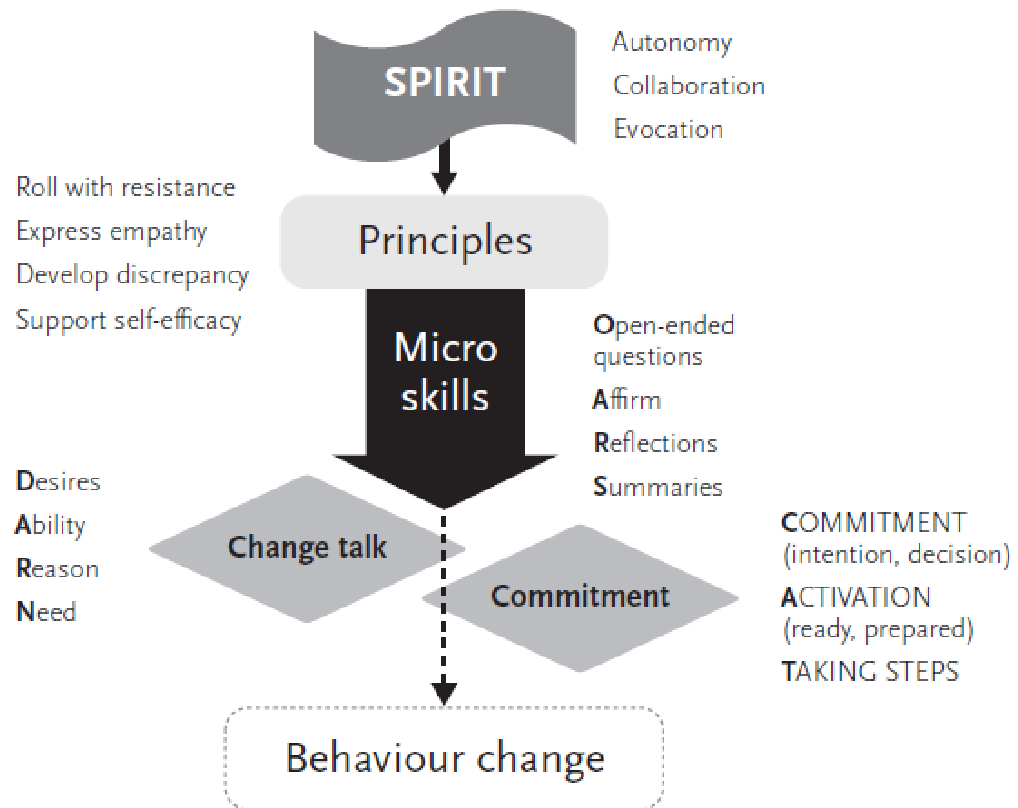
- Only when they …
  - become **Interested and Concerned** about the need for change
  - become **Convinced** change is in best interest or will benefit them more than cost them
  - organize P**lan of Action** that they are **Committed** to implementing
  - **Take the Actions** necessary to make and sustain the change

What is Motivational Interviewing

- A collaborative conversation style for strengthening a **person's *own* motivation** and commitment to change.
  - *"Motivational interviewing is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence."*



The Framework of Motivational Interviewing



Source: MINT Training, Centre for Addiction and Mental Health.

3 Communications Style
Lead
Tell
Direct
Guide
Encourage
Support
Observe
Permit
Follow

The “Spirt” of MI

Partnership/Collaboration	Patient/Client is the expert. Developing a partnership in which the patient’s expertise, perspectives, and input are central to the consultation.
Evocation	Motivation is enhanced by eliciting and drawing on the patient’s own perceptions, experiences, and goals. Use open-ended questions.
Acceptance (“autonomy”)	The person has the potential to move in the direction of health.
Compassion	Belief and commitment to act in the best interests of the patient.

Miller & Rollnick

https://youtu.be/eaD_Py5ZYQE

Four Processes of MI

Engaging
- Shall we travel together

Focusing
- Where are we going?

Evoking
- Why travel?

Planning
- How and When?

Engaging

- Engagement is the thermometer for the likelihood of change

- People are drawn to things that feel safe, useful, helpful, and hopeful

Engagement Process

- The minute you enter into an interaction with someone the engagement process has started.
  - This includes walking into the room.
  - The space in which you meet with the person.
  - "First impressions."
- People are looking to see if they can trust you AND decide what they'll share and whether or not they'll come back to talk to you.
- Engagement is a necessity.

5 Key Principles to Build Engagement

Principle	Key Points
Express empathy	All behavior serves a purpose Ambivalence is normal Reflective listening is fundamental
Develop Discrepancy	Awareness of consequences Discrepancy between present behavior and future goals Client driven
Avoid Argumentation	Counterproductive Breeds defensiveness Resistance is a signal to change your strategy Labeling is unnecessary
Roll with Resistance	Perceptions can be shifted Gives you information Invite new ideas – don't impose Client holds the key to change
Support Self-Efficacy	Belief in the individual Responsible for choosing their path and creating change Hope in future alternatives

Miller & Rollnick

Express Empathy

Why is empathy important in MI?

- Communicates acceptance, which facilitates change
- Encourages a collaborative alliance, which also promotes change
- Leads to an understanding of each person's unique perspective, feelings, and values, which make up the material we need to facilitate change

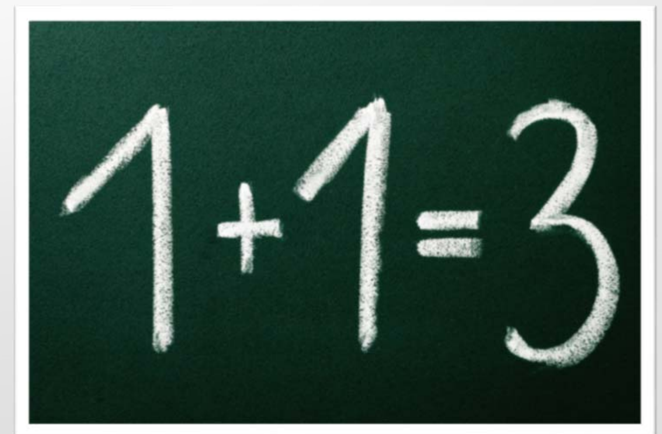
Tips…

- Good eye contact
- Responsive facial expression
- Body orientation
- Verbal and nonverbal "encouragers"
- Reflective listening/asking clarifying questions
- Avoid expressing doubt/passing judgment

Develop Discrepancy

- Current behavior versus future goals

Example: *"Sometimes when you drink during the week, you can't get out of bed to get to work. Last month, you missed 5 days. But you enjoy your work, and doing well in your job is very important to you."*



Avoid Argumentation

- Arguing with someone causes defensiveness.
- They already have heard the arguments and have prepared a response.
  - "Yeah but..."
- You cannot win… nor is that the goal.
  - You want to support their self-efficacy and remain client/patient-centered.

Roll With Resistance

Examples

Patient: *I don't plan to quit drinking anytime soon.*

Clinician: *You don't think that abstinence would work for you right now.*

Or

Patient: *My husband is always nagging me about my drinking—always calling me an alcoholic. It really bugs me.*

Clinician: *It sounds like he really cares about you and is concerned, although he expresses it in a way that makes you angry.*

Roll with Resistance: https://youtu.be/ef9kPpZGJX8

Support Self-Efficacy

- Patients are responsible for choosing and carrying out actions to change.
- They may not be ready or willing to change right now and you cannot force them.
- Return to basic engagement.

WHETHER YOU
THINK YOU CAN,
OR THINK YOU CAN'T.
YOU'RE RIGHT.

OARS

1. **Open-ended questions**
   - Enables the patient to convey more information
   - Encourages engagement
   - Opens the door for exploration
2. **Affirmations**
   - Statements acknowledging the patient's strengths and efforts
   - Conveys belief in the patient's ability to make desired changes
3. **Reflections**
   - Involves listening and understanding the meaning of what the patient says
   - Accurate empathy is a predictor of behavior change
4. **Summaries**
   - Periodically summarize what has occurred in the conversation
   - Conveys that the patient is being heard

1. Ask Open Questions

- Avoids the question-answer trap.
- Do not listen to reply… listen to understand!
- Helps explore the individual rather than you deciding what is important
  - What brings you here today?
  - What concerns you the most?
  - How have you been doing since the last time I saw you?
  - Tell me more about…?

2. Affirming

- To recognize and acknowledge that which is good, including the individual's worth as a human being. It is supportive & encouraging. It overlaps with empathy.
- MUST BE DONE SINCERELY
- "You did this…" rather than "I am proud of you for…"
  - Focus on the individual not yourself or the "thing/reason"
  - It is is not the same as praise
  - Affirmations can reframe imperfection, doubt, or apparent failure
  - Affirmations can relate to specific behaviors
  - Emphasize something relevant to your work with them
- Examples:
  - *"You really tried hard this week!"*
  - *"Even though it didn't turn out exactly as you hoped, look at what you were able to accomplish!"*
  - *"You were really discouraged, but you hung in there. Awesome!"*
  - *"Listening to all you've been through, I'm not sure I could've come out as well as you did. You are a survivor."*
  - *"You're the kind of person that puts a lot of thought into something"*

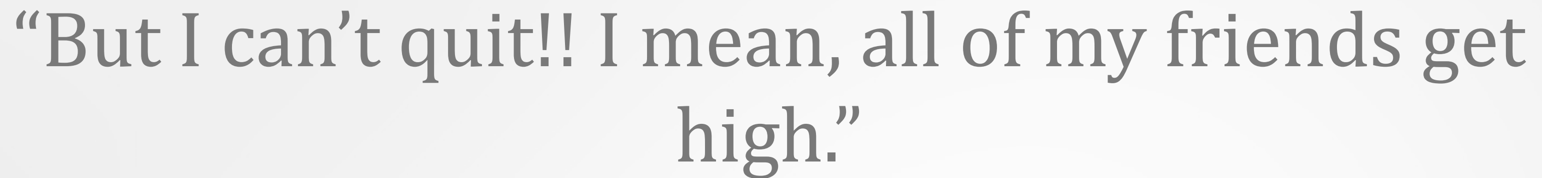
Affirmations: https://youtu.be/tbQlCrVMpew

Reflections

- **Simple Reflection** —stays close to what you heard - restates
  - Example
    - *Patient: I hear what you are saying about my drinking, but I don't think it's such a big deal.*
    - *Clinician: So, at this moment you are not too concerned about your drinking.*
- **Complex Reflection** —makes a hypothesis or moves towards more meaning
  - Paraphrasing—major restatement, infers meaning, "continuing the paragraph"
  - Examples:
    - ***Content**: You see a connection between your drug use and the possibility of going back to jail.*
    - ***Feeling**: You are worried that if you continue to use you might end up back in jail.*
    - ***Meaning**: You children are important to you and you want to be there for them.*

Reflections: https://youtu.be/kDd0cG19krU

"But I can't quit!! I mean, all of my friends get high."



- **Simple**: "Quitting seems difficult because you spend a lot of time with people who smoke"
- **Amplified**: "There's NO WAY you can quit because you'd lose ALL your friends"
- **Double-sided**: "You can't imagine how you could be around your friends and not get high but at the same time you're worried about the consequences of your use."
- **Shifting Focus**: "I don't want to get stuck on the act of quitting right now; lets focus on talking through the issues and we can decide what to do about it later."
- **Reframe**: "It's important that your friends are protected while you figure out your thoughts about using."
- **Agree with a Twist**: "You are feeling like quitting brings with it big personal risks and yet you're still trying to figure out some possible solutions."
- **Coming Alongside**: "Quitting your use comes with too big of a lost to your social life. It just don't feel worth it right now."

4. Summarizing

1. Collecting – bring together interrelated statements
2. Linking – connect to something said before
3. Transitional – highlight important details and move towards something new

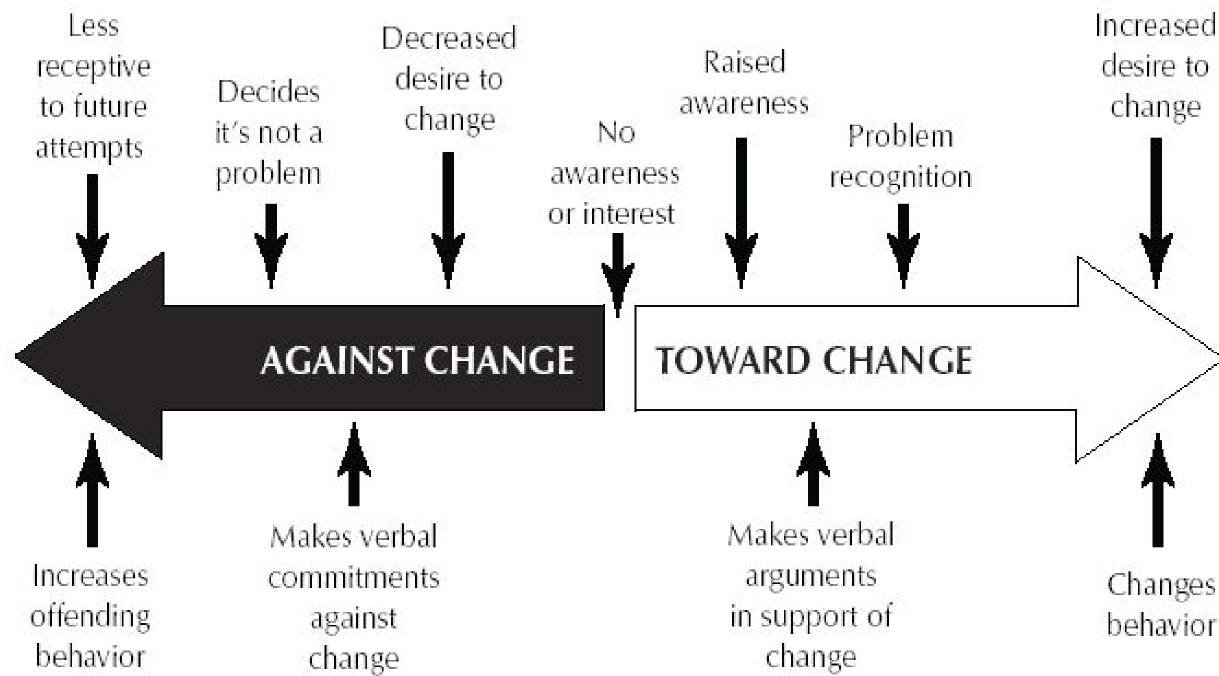
Examples:

- *“So, let me see if I’ve got this right…”*
- *“So, you’re saying… is that correct”*
- *“Make sure I’m understanding exactly what you’ve been trying to tell me…”*

5. Informing & Advising

- MI providers should not offer unsolicited expert opinions in a highly directive style.
  - They should also only offer advice **with permission or when the client asks for it**.
  - Must understand the client's perspective and needs and make sure your shared information is relevant.
- **The client is always free to reject, implement or not, and heed or not the advice.**
- 3 forms of permission:
  1. Person asks for permission or advice
  2. You ask permission to give it
  3. Offer permission for disagreement
- What is an example of offering a statement someone can disagree with?

Core Motivational Interviewing Skills



Move Conversation Towards Change Talk

- Change talk is any self-expressed language that is an argument for change.
- You can elicit change talk by using **Strategic Questions**:
  - You have cut down on your drinking before. What made that work for you then?
  - What are some reasons you've thought about making a change?
  - If you woke up tomorrow and things were different, what would it look like?

"I wish I could stop drinking so much because I don't want that to be an example for my children."

Elicit Change Talk:
https://youtu.be/LIFeqt1h3gU

Miller & Rollnick,2012

Preparatory Change Talk

- pro-change side of ambivalence

DARN

Desire (I want to change)	"I want to lose some weight." "I hope to get better grades."
Ability (I can change)	"I can…" "I am able to…" "I would be able to figure that out."
Reason (It's important to change)	"I would probably have more energy." "I might sleep better at night." "I want to be around to see my grandkids."
Need (I should change)	"I need to…" "I have to…" "I must…" "I've got to …"

Mobilizing Change Talk

- movement towards resolution

CAT

Commitment (I will make changes)	To say that one must, can, wants to, or has good reasons to change is not to say that one will. Committing language signals the likelihood of action. "I want to" "I could." "I have good reasons to."
Activation (I am ready, prepared, willing to change)	Indicate movement towards action but not yet commitment to do so. "I am willing to…" "I am ready to…"
Taking Steps (I am taking specific actions to change)	Already done something in the direction of change. "I bought some running shoes so I can exercise." "This week I didn't snack in the evening." "I finished my CV."

Promoting change talk will require you to respond to Ambivalence

- Arguments both for & against change are already in the mind of the ambivalent person.
- The person has heard all the good arguments from others
- The response is pretty predictable – “Yes, but..”
- Ambivalent people are often viewed as “oppositional,” “in denial” or “resistant”
  - *“I have mixed feelings”*
  - *“I want to change, but I don’t think I can.”*
  - *“Sometimes I do, sometimes I don’t.”*
  - *“Yes, but……..”*

- In truth, ambivalence is totally normal and is not something bad about the person. See it as expected!

Miller & Rollnick,2012

I swear…

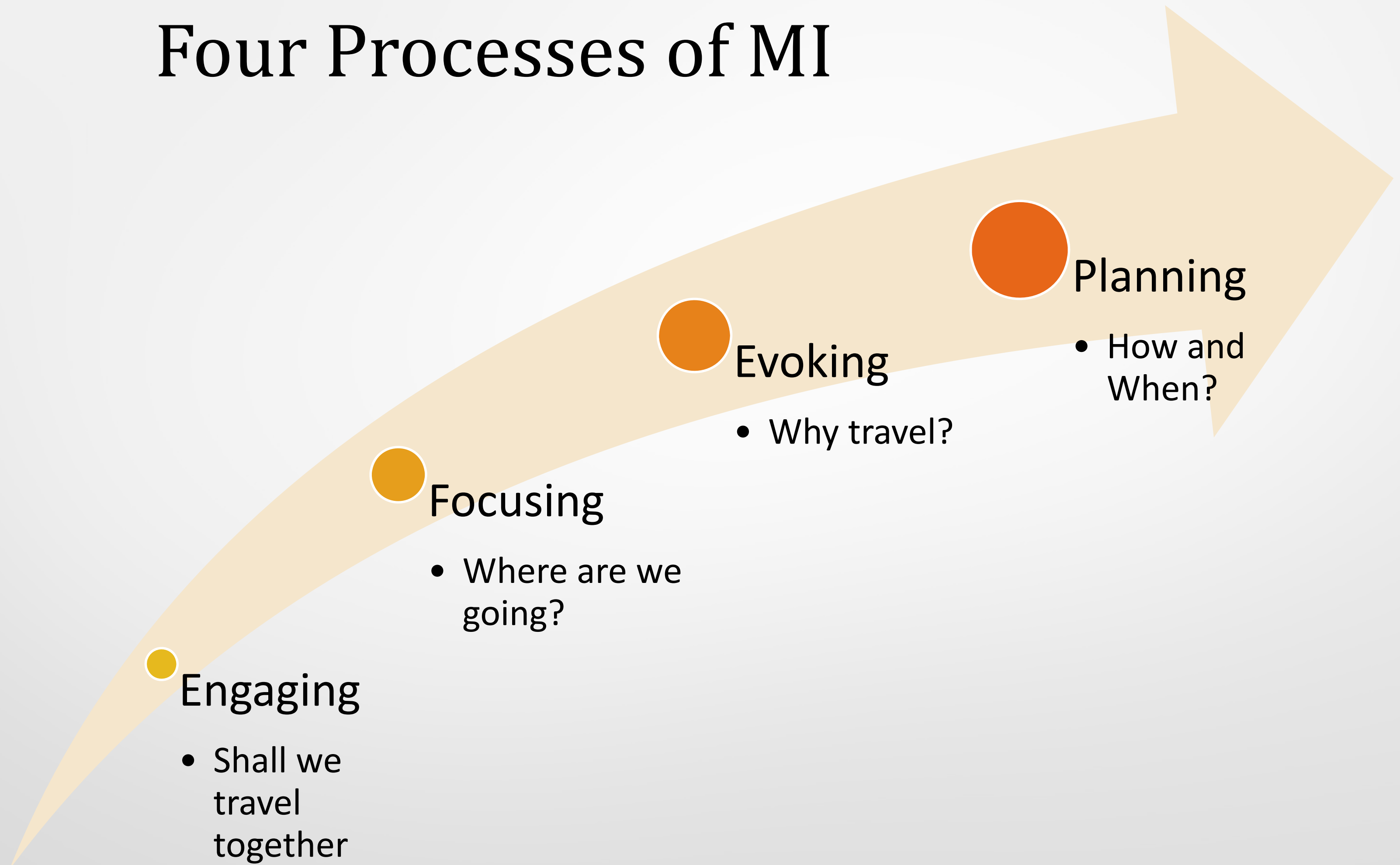
- I want to.
- I could.
- I have good reason to.
- I need to.
- I will.

Using Reflects to Promote Change

- "I really don't want to stop smoking [sustain talk], but I know that I should [change talk]. I've tried before and it's really hard [sustain talk]."

- Which should you reflect:
  - You really don't want to quit.
  - It's pretty clear to you that you ought to quit.
  - You're not sure if you can quit.

Four Processes of MI



Evoke Motivation

Decisional Balance

- Highlights pros and cons of change
- Acknowledges and validates ambivalence
- Building understanding, empathy, and contributes to the working alliance
- Helps move someone towards change talk
- Develops discrepancy between where they are now and where they'd like to be.

	Not Changing Behavior	Changing Behavior
Pros	**Box 1**: What is something good that could come from *not* taking this action?	**Box 4**: What is something good that could come from taking this action?
Cons	**Box 2**: What is something bad that could come from *not* taking this action?	**Box 3**: What is something bad that could come from taking this action?

Use Importance Ruler

- *"How important is it for you to…?"*
- *"On a scale from 0-10, where 0 means 'not at all important' and 10 means 'the most important thing for me right now,' how important would you say it is for you to…?"*

On a scale of 0 to 10, how IMPORTANT is it for you right now to change?

0____1____2____3____4____5____6____7____8____9____10

Not at all Important — Extremely Important

- ❑ *"Wow, you're a 2 and not a 0! That's awesome; Why is that?"*
- ❑ *What would it look like to be a 10 rather than a 9?*
- ❑ *What would it take to move to you to a 3 (from a 2)?*
- ❑ *How could we work together to make you more confident?*
- ❑ *What might make this more important?*
- ❑ *What do you need to feel more ready?*
- Do not ask *"why are you a 3 and not an 8?"*

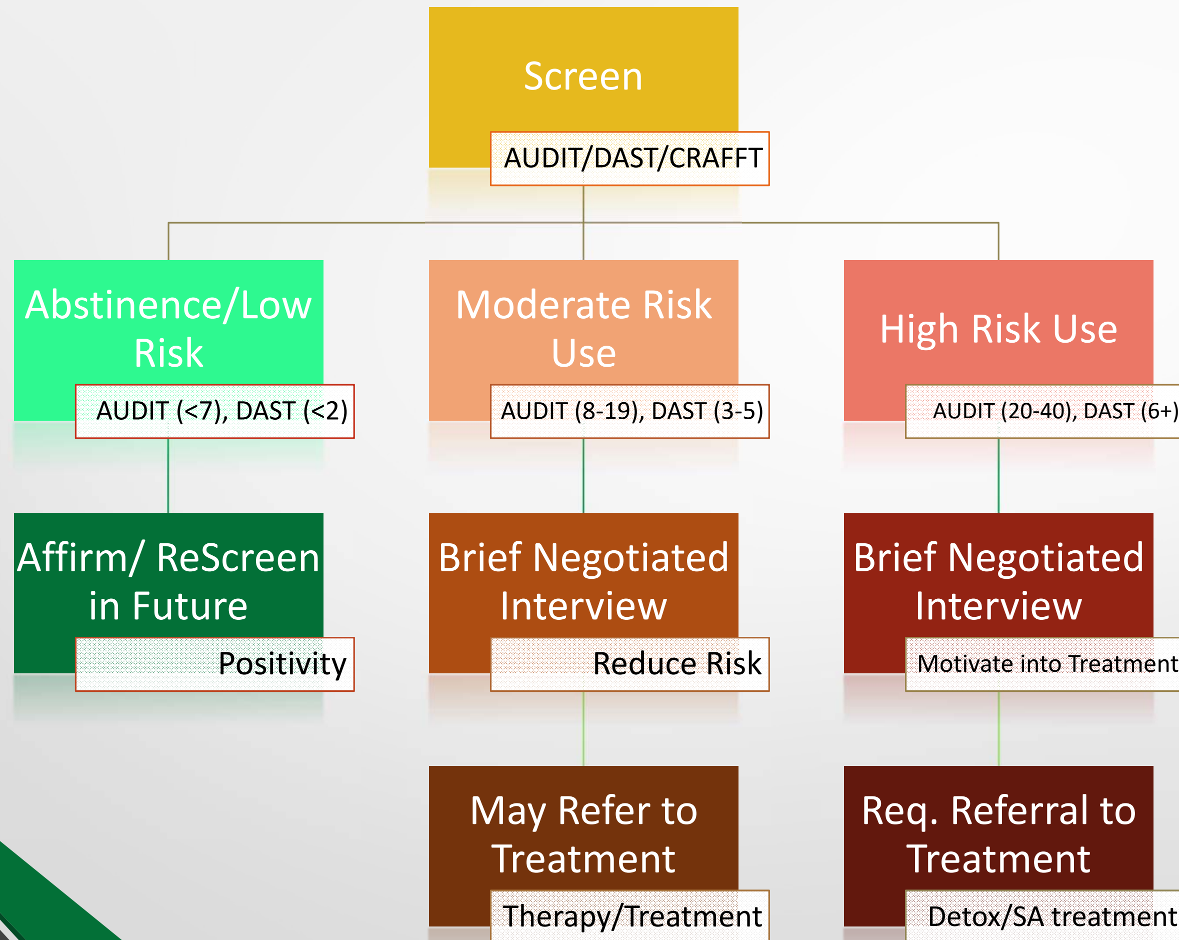
https://www.youtube.com/watch?v=Ng_N__iciJM

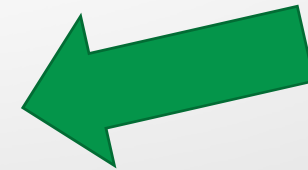
- The client will tell you when they’re ready to move stages.
- Still using MI – don’t suddenly become directive or the expert.
- Notice the following signs:
  - Increased change talk
  - Taking steps
  - Diminished sustain talk
  - Resolve
  - Envisioning
  - Questions about change

Change Plan

S	• **Specific:** State exactly what you want to accomplish (Who, What, Where, Why)
M	• **Measurable:** How will you demonstrate and evaluate the extent to which the goal has been met?
A	• **Achievable:** stretch and challenging goals within ability to achieve outcome. What is the action-oriented verb?
R	• **Relevant:** How does the goal tie into your key responsibilities? How is it aligned to objectives?
T	• **Time-bound:** Set 1 or more target dates, the "by when" to guide your goal to successful and timely completion (include deadlines, dates and frequency)

Post-Screening – Time to "Do Something"





Brief Negotiated Interview & Referral to Treatment

Applying the steps from MI to an evidence-based brief intervention to motivate the client to risk-reducing behaviors or treatment.

What Is a Brief Intervention (BI)?

- Brief Intervention is a brief motivational and awareness-raising intervention given to risky or problematic substance users.
  - There are several models for brief intervention, including the Brief Negotiated Interview
  - The BNI is a semi-structured interview process based on MI that is a proven evidence-based practice and can be completed in 5–15 minutes.

(Gail D'Onofrio, M.D., Ed Bernstein, M.D., Judith Bernstein, M.S.N., Ph.D., & Steven Rollnick, Ph.D.) Special acknowledgement is made to Drs. Stephen Rollnick, Gail D'Onofrio, and Ed Bernstein for granting permission to orient participants to the "brief negotiated interview."

Steps in the BNI

The BNI is built on 4 main steps:

1. Build Rapport—Raise the Subject.
   - Explore the pros and cons of use (decisional balance from MI)
2. Provide feedback.
3. Build readiness to change.
4. Negotiate a plan for change.

1. Build Rapport—Raise the Subject

- Begin with a general conversation.
- Ask permission to talk to them about their alcohol or drug use.

- What if the patient does not want to talk about his or her use? Many people are reluctant or caught off guard.
  - Focus on building the relationships or paving the way for future conversations or interventions.
  - Normalize the conversation.
  - Discuss the Pros and Cons of Use: *"Help me understand through your eyes…"*
    - What are the good things about using alcohol?
    - What are some of the not-so-good things about using alcohol?

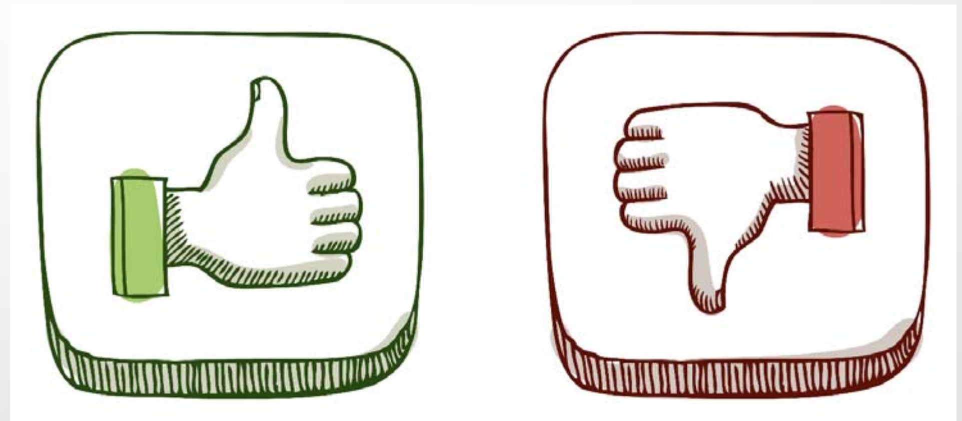
2. Provide Feedback

1. Ask permission to give information.
   - Educational info
   - De-normalize their use
   - They may be unaware
2. Discuss screening findings.
3. Link substance use behaviors to any known consequences.
   - Legal, social, relational, emotional, financial…
4. Evoke a response:
   - Positive reaction—move forward
   - Negative reaction—revisit the pros and cons
     - Do not become defensive

Discuss the Pros and Cons of Use—Applying MI

Using open-ended questions

- Enables the patient to convey more information
- Encourages engagement
- Opens the door for exploration



Using reflections

- Reflective listening
- Thinking reflectively

Summarizing

- Reinforces what has been said
- Shows careful listening

3. Build Readiness To Change

- *Use scaling questions*
  - *Could we talk for a few minutes about your interest in making a change?*
  - *On a scale from 0 to 10, 0 being not important at all and 10 being incredibly important, how important is it for you to make any changes in your substance use?*

4. Negotiate a Plan for Change

- A plan for reducing use to low-risk levels

OR

- An agreement to follow up with specialty treatment services

Example Interviews: Video 1

http://www.ed.bmc.org/sbirt/media/doctor_a.html

Anti-SBIRT (Doctor A)

This case example demonstrates how ineffective a conversation with a patient can be when the health care provider judges the patient, tells him what to do, and loses his temper.

This increases the patient's defensiveness and "resistance", making him less likely to listen and trust the provider's feedback. It might make the patient just as likely to repeat the harmful behaviors that required emergency care.

The interaction might have gone more smoothly, and the provider might have been more influential, if he had used SBIRT techniques.

Video 2

http://www.ed.bmc.org/sbirt/media/doctor_b.html

Using SBIRT Effectively (Doctor B)

This case example demonstrates an ideal SBIRT Brief Negotiated Interview between an emergency department (ED) doctor and a patient. The patient is in the ED for car accident injuries related to his own drunk driving. The doctor has a respectful, nonjudgmental conversation with him to explore the possibility of changing his alcohol use and/or seeking treatment.

Video 3

http://www.ed.bmc.org/sbirt/media/case1.html

SBIRT for alcohol use: college student.

The patient is in the hospital for a head injury related to falling down while intoxicated. The health care provider has a respectful, nonjudgmental conversation with her to explore the possibility of changing her drinking behavior (cutting back on quantity and frequency).

SBIRT for alcohol use: college student. (2011). United States: Boston University School of Public Health BNI Art Institute. Retrieved from http://www.youtube.com/watch?v=SvqjTOnp_SM

Referral to Treatment

MUSBIRT
Screening, Brief Intervention and Referral to Treatment

- It is well established that substance abuse treatment can be effective!
- Following are strategies to realize the greatest likelihood of a successful treatment referral.

What Is Treatment?

- Substance abuse treatment is provided at different levels of care and is often available in multiple treatment settings.
- The level of care is determined by severity of problem and use.
  - It is most important to find out: Is the client a dependent or nondependent substance abuser, and are there medical or psychiatric co-occurring disorders?
- Inpatient treatment is reserved for those with more serious use (dependence, comorbidity) or those requiring detox.
- Client-centered

Treatment may include:

- Counseling, therapy, and other psychological rehabilitation services
- Medications: psychiatric for co-occurring disorders (in conjunction with talk-therapy) or Drug agonist (Buprenorphine) antagonist (naltrexone) therapy
- Self-Help or Support Groups(AA, NA, Al-Anon)
- Health & wellness coaching (diet, exercise, meditation)
- Combinations of the above

CONTINUUM OF CARE:

INTENSITY SPECTRUM OF SERVICES

Health Promotion & Prevention
- Healthy communities
- Wellness plans
- Education

Early Intervention
- Access through needle exchange, primary care, judicial system, etc.
- Screening
- Referral

Community Based
- 12 Step Meetings
- Support Groups
- Day Programs

Outpatient Services
- Co-Occuring treatment
- Medication-assisted
- Daily, Weekly, Monthly
- Psychiatric services
- Indvidual, Family, or Group therapy

Residential Services
- Short Term (28 days, 90 days, 3-6 months)
- Long Term (6-12 months)
- Population Specific
- Faith-based

Hospitalization
- Medication management
- Detox
- Stabilization

Detox?

- Clinical Findings: To qualify, patient must meet the diagnostic criteria for a DSM Axis I or ICD-9 Substance Dependence diagnosis. Must have one of the following:
  - 1. Nature and pattern of use of abused substance (including frequency and duration) predicts the potential for clinically significant withdrawal necessitating 24-hour medical intervention to prevent complications and that is not appropriate for a lower level of care- e.g. **alcohol and benzodiazepine withdrawal** (note: withdrawal from stimulants or marijuana alone generally does not require a medical detoxification and opiate detoxification is often appropriate for a lower level of care).
  - 2. Presence of active withdrawal symptoms that can not be safely or effectively managed at a lower level of care-e.g. tremors, unstable vital signs, diaphoresis, GI disturbances, agitation, withdrawal hallucinations, confusion or disorientation or seizures.
- Note: Patients who experience severe psychological withdrawal symptoms may require 24-hour care, even though they do not meet the detoxification criteria. Please refer to rehabilitation and psychiatric criteria.

What Is a Warm-Handoff Referral?

- The "warm-handoff referral" is the action by which the clinician directly introduces the patient to the treatment provider at the time of the patient's medical visit. The reasons behind the warm-handoff referral are to establish an initial direct contact between the patient and the treatment counselor and to confer the trust and rapport. Evidence strongly indicates that warm handoffs are dramatically more successful than passive referrals.

ONE Call. ONE Text. ONE Click. Instant HELP.

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HELP4WV.com

Many of those answering the 24/7 helpline are peer-support specialists or recovery coaches. This means that they have personal experience in recovery from a mental health or substance abuse issue. The helpline staff offers confidential support and resource referrals, including self-help groups, out- patient counseling, medication-assisted treatment, psychiatric care, emergency care, and residential treatment.

The helpline provides assistance for those who need help themselves, and guidance for those seeking help for loved ones. It is also an ideal way for social workers, nurses, and others involved in discharge or care planning to access a comprehensive list of state resources.

National Referral Resources

- SAMHSA's National Treatment Facility Locator
  http://findtreatment.samhsa.gov

Questions?

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Resources

- SAMSHA: http://www.samhsa.gov/sbirt
- The Association for Medical Education and Research in Substance Abuse https://amersa.org/
- American Society of Addiction Medicine http://www.asam.org/
- National Institute of Alcohol Abuse and Alcoholism http://www.niaaa.nih.gov/
- Missouri SBIRT resources : https://adept.missouri.edu/Portals/0/MU-ADEPT_AdvancedTrainingResources.heatherATTC12.pdf
- Yale School of Medicine http://medicine.yale.edu/sbirt/curriculum/
- Baylor SBIRT medical residency training: https://www.bcm.edu/education/programs/sbirt/index.cfm?PMID=0
- Rhode Island Hospital training: http://www.rhodeislandhospital.org/sbirt.html

Video Resources

- Yale training videos: http://medicine.yale.edu/sbirt/curriculum/video/
- Missouri training videos: https://adept.missouri.edu/Resources.aspx
- MD online module for faculty: http://www.sbirt.umaryland.edu/Medical-Faculty-Supervision-Training/Online-Module-for-Faculty/
- MD residency training videos: http://www.sbirt.umaryland.edu/Medical-Residency-Training-Program/MD3-Training-Videos/
- CO SBIRT channel: https://www.youtube.com/channel/UCCB4xnHTyWMRT_HFJhO0BAQ
- IRETA channel: https://www.youtube.com/playlist?list=PLiML4AFpuB71TAqFWZga6XFuf7j8LLSGp
- Baylor Med training: https://www.bcm.edu/education/programs/sbirt/online